

FORM 117



The Commonwealth of Massachusetts  
 Department of Industrial Accidents -- Department 117  
 600 Washington Street - 7th Floor, Boston, Massachusetts 02111  
 Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470  
<http://www.state.ma.us/dia>

DIA Board #  
 (If Known):  
 26642-11

**AGREEMENT FOR REDEEMING LIABILITY**  
**BY LUMP SUM UNDER G.L. CH. 152**  
**FOR INJURIES OCCURRING ON OR AFTER NOV. 1, 1986**

Page 1 of 2  
 Please Print or Type

EMPLOYEE	Liliana Medina	LUMP SUM AMOUNT	\$ 15,000.00
EMPLOYER	Trustees of Philips Academy	TOTAL DEDUCTIONS	\$ 2,266.50
INSURER	NEEIA Compensation, Inc.	NET TO CLAIMANT	\$ 12,733.50
BOARD NUMBER	26642-11	TOTAL PAYMENTS	\$ 15,000.00

(Weekly benefits plus lump sum)

DATE OF INJURY 9/30/2011

CHECK WHERE APPLICABLE

( ) Liability has been established by acceptance or by standing decision of the Board, the Reviewing Board, or a court of the Commonwealth and this settlement shall not redeem liability for the payment of medical benefits and vocational rehabilitation with respect to such injury.

(X) Liability has NOT been established by standing decision of the Board, the Reviewing Board, or a court of the Commonwealth and this settlement shall redeem liability for the payment of medical benefits and vocational rehabilitation benefits with respect to such injury.

( ) In addition to the lump-sum, the insurer agrees to pay all outstanding reasonable and related medical bills incurred as of this date.

( ) The employee is currently receiving a cost-of-living adjustment.

DEDUCTIONS: From the lump-sum amount as stated above, the amount(s) listed below will be deducted and paid directly to the following parties:

	NAME	ADDRESS
1. \$ 2,250.00 Attorney's Fee	D'Angelo & Hashem LLC	401 Andover St., Ste. 202, N. Andover, MA 01845
2. \$ 16.50 Attorney's Expenses	D'Angelo & Hashem, LLC (Please attach documentation)	DEPARTMENT OF INDUSTRIAL ACCIDENTS DIVISION OF DISPUTE RESOLUTION APPROVED MAY 10 2012 by [Signature] Administrative Judge In Accordance with MASS. G.L.c.152
3. \$ _____ Licens	Please attach discharges	
4. \$ _____ Inchoate Rights	(Please specify release)	
5. \$ _____		
6. \$ _____		
7. \$ _____		

(OVER)



## AGREEMENT FOR REDEEMING LIABILITY BY LUMP SUM SETTLEMENT

(Page 2 of 2)

## EMPLOYEE MEDICAL INFORMATION:

Age 47 No. of Dependents 2 Average Weekly Wage \$ 883.60 Compensation Rate \$ 530.16Social Security No.\*: ██████████ Occupation Gift Receiver Educational Background some college

On Social Security: YES( ) NO(x)

On Public Employee Disability Retirement: YES( ) NO(x)

DIAGNOSIS anxiety, stress PRESENT MEDICAL CONDITION FairPresent Work Capacity: Disabled Third Party Action NonePLEASE GIVE A BRIEF HISTORY OF THE CASE AND INDICATE WHY THE SETTLEMENT IS  
IN THE EMPLOYEE'S BEST INTEREST (Specify all allocations):

Ms. Medina alleges she participated in a meeting with her supervisor and coworkers on September 30, 2011, wherein one coworker allegedly made threats against her. Following this meeting, she presented to Exeter Hospital with headaches. She was treated initially by her primary care physician, Dr. Michael Romanowsky, and was referred for psychological counseling to Sylvia Von Sacken, LICSW. Ms. von Sacken diagnosed EE with post-traumatic stress and anxiety, with a major depressive episode. EE has not returned to work. It is mutually agreed by the parties, including EE, Employer/Self-Insurer, that this settlement closes out any potential claims, including those under Sec. 28 and section 36 the EE may have. Liability has not been accepted. Self-Insurer shall pay the following amounts: \$ 15,000 to EE, D'Angelo & Hashem, LLC, which includes settlement and Attorney Wolman's claims for legal services and expenses per 452 CMR 1.02. The proposed settlement is a compromise representing potential future § 34 or 35 benefits without the risk of the Self-Insurer prevailing in its opposition. An appropriate Sciarotta Allocation has been made. The proposed settlement represents payment of benefits over employee's life expectancy of 37.6 years in the weekly amount of \$ 7.67. Given the EE's age, education, and work history, it is rational to prorate the net settlement proceeds over her life expectancy, and the compromise is reasonable. This agreement shall take effect upon approval by the U.S. Bankruptcy Court for the District of New Hampshire, in the matter of In re: Woodrow M. & Lilianna Medina, 1:12-bk-10166.

(Please attach a separate sheet if necessary.)

Received of NEEIA Compensation, Inc. the Lump Sum of fifteen thousand  
dollars and Zero cents (\$ 15,000.00)

This payment is received in redemption of the liability of all weekly payments now or in the future due me under the Workers' Compensation Act, for all injuries received by Lilianna Medina  
on or about 9/30/2011 while in the employ of Trustees of Phillips Academy  
. I fully understand that after all of the deductions herein I will receive  
\$ 12,733.50 . I am fully satisfied with and request approval of this settlement. This agreement has been  
translated for me into my native language of n/a .

CLAIMANT:	SIGNATURE	ADDRESS	ZIP CODE
<u>Lilianna Medina</u>	<u>87 Hickory Road</u> <u>Hampstead, NH</u>	<u>03841</u>	
CLAIMANT'S COUNSEL:	<u>J. A. D.</u>	<u>401 Andover St., Ste. 202</u> <u>N. Andover, MA</u>	<u>01845</u>
INSURER'S COUNSEL:	<u>E. D. T.</u>	<u>1383 Main St., Ste. 203</u> <u>Springfield, MA</u>	<u>01103</u>

Signed this 24 day of April 2012.

HealthPort  
 P.O. Box 409740  
 Atlanta, Georgia 30384-9740  
 Fed Tax ID 58 - 2659941  
 (770) 754 - 6000


**HealthPort**  
**INVOICE**

Invoice #: 0104668437  
 Date: 2/9/2012  
 Customer #: 1560966

Ship to:

JAY M WOLMAN  
 DANGELO AND HASHEM  
 401 ANDOVER ST STE 202  
 NORTH ANDOVER, MA 01845

Bill to:

JAY M WOLMAN  
 DANGELO AND HASHEM  
 401 ANDOVER ST STE 202  
 NORTH ANDOVER, MA 01845

Records from:

EXETER HOSPITAL  
 FIVE ALUMNI DRIVE  
 EXETER, NH 03833

Requested By: DANGELO AND HASHEM  
 Patient Name: MEDINA LILIANA

DOB: 032165

Description	Quantity	Unit Price	Amount
Basic Fee			15.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1	17	0.00	0.00
Shipping			1.50
Subtotal			16.50
Sales Tax			0.00
Invoice Total			16.50
Balance Due			16.50

Pay your invoice online at [www.HealthPortPay.com](http://www.HealthPortPay.com)

Terms: Net 30 days

Please remit this amount : \$ 16.50 (USD)

HealthPort  
 P.O. Box 409740  
 Atlanta, Georgia 30384-9740  
 Fed Tax ID 58 - 2659941  
 (770) 754 - 6000

Invoice #: 0104668437

Check # \_\_\_\_\_

Payment Amount \$ \_\_\_\_\_

Please return stub with payment.

Please include invoice number on check.

To pay invoice online, please go to [www.HealthPortPay.com](http://www.HealthPortPay.com) or call (770) 754 6000.Email questions to [Collections@healthport.com](mailto:Collections@healthport.com).

FORM 116C



The Commonwealth of Massachusetts  
Department of Industrial Accidents – Department 116C  
600 Washington Street – 7th Floor, Boston, Massachusetts 02111  
Info. Line 800-323-3249 ext. 470 in Mass. • Outside Mass. – 617-727-4900 ext. 470  
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DIA Board #  
(If Known):  
26642-11

**LIEN DISCLOSURE FORM**  
**TO BE COMPLETED BY THE EMPLOYEE**

I,

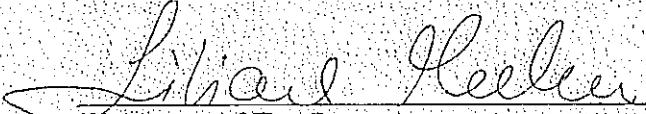
Liliana Medina

(Print Name)

hereby certify that, to the best of my knowledge, there are no outstanding liens or claims for reimbursement out of the proceeds of my workers' compensation settlement by the Department of Transitional Assistance, Department of Revenue Child Support Enforcement Unit, Veterans Services, prior counsel, or any medical, dental, hospital or disability income provider. My workers' compensation DIA Board number(s) is (are):

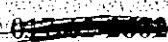
26642-11

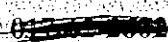
*SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY.*

  
Signature of Employee

87 Hickory Road  
Hampstead, NH 03841

Address of Employee

  
Social Security Number

  
5/10/12  
Date

\*Disclosure of Social Security Number is voluntary. It will assist in the processing of this document.

Reproduce as needed.

Form 116C Revised 8/2001

PSC (800) 51-TURBO